Waltham Forest

Briefing note to GPs and clinicians re: Outbreak of Clade I mpox in the African Region and implications for diagnosis and testing in the UK

Call to action for clinicians

Clinicians are asked to:

1. Be alert to the possibility of clade I mpox in all patients with suspected mpox if there is a link to the specified countries in the African region (listed on page 3).
2. Have a low threshold for testing for mpox in patients with clinically compatible presentations with a travel history irrespective of sexual history.
3. Isolate patients meeting the following criteria as a high consequence infectious disease and contact the Imported Fever Service to discuss urgent testing and typing:

   Confirmed or clinically suspected mpox cases but clade not yet known and:

   - there is a travel history to the DRC or specified countries where there may be a risk of clade I exposure, or a link to a suspected case from specified countries (listed on page 3), within 21 days of symptom onset and/or there is an epidemiological link to a case of Clade I mpox within 21 days of symptom onset

4. Discuss any patient with suspected mpox and severe or disseminated disease with the Imported Fever Service, even if no travel history is identified.
5. Notify the local Health Protection teams on suspicion of Clade I mpox.

Context

Clade I mpox virus (MPXV) is a high consequence infectious disease (HCID) which may be more severe and transmissible than the clade II mpox, which has been present in the UK since 2022.

Clade I mpox virus has historically only been reported in five countries in Central Africa. There is now increasing transmission of clade I mpox in the Democratic Republic of Congo (DRC), and cases are also being reported from other surrounding countries in Central and East Africa. A single case has also been reported in Sweden. As of 27/08/2024, no cases have been reported in the UK however, the rapid spread of Clade I MPVX has prompted this briefing to limit any risk posed to the UK public.

Clinical features

The incubation period is the duration/time between contact with the person with mpox and the time that the first symptoms appear. The incubation period for mpox is between 5 and 21 days.

Mpox infection is usually a self-limiting illness, and most people recover within several weeks. However, severe illness can occur in some individuals. HCID mpox is known to cause more severe disease than non-HCID mpox clades with case fatality rates of 10% reported in non-vaccinated individuals previously. The illness begins with:

- fever
- headache
- muscle aches
- backache
- swollen lymph nodes
- chills
- exhaustion

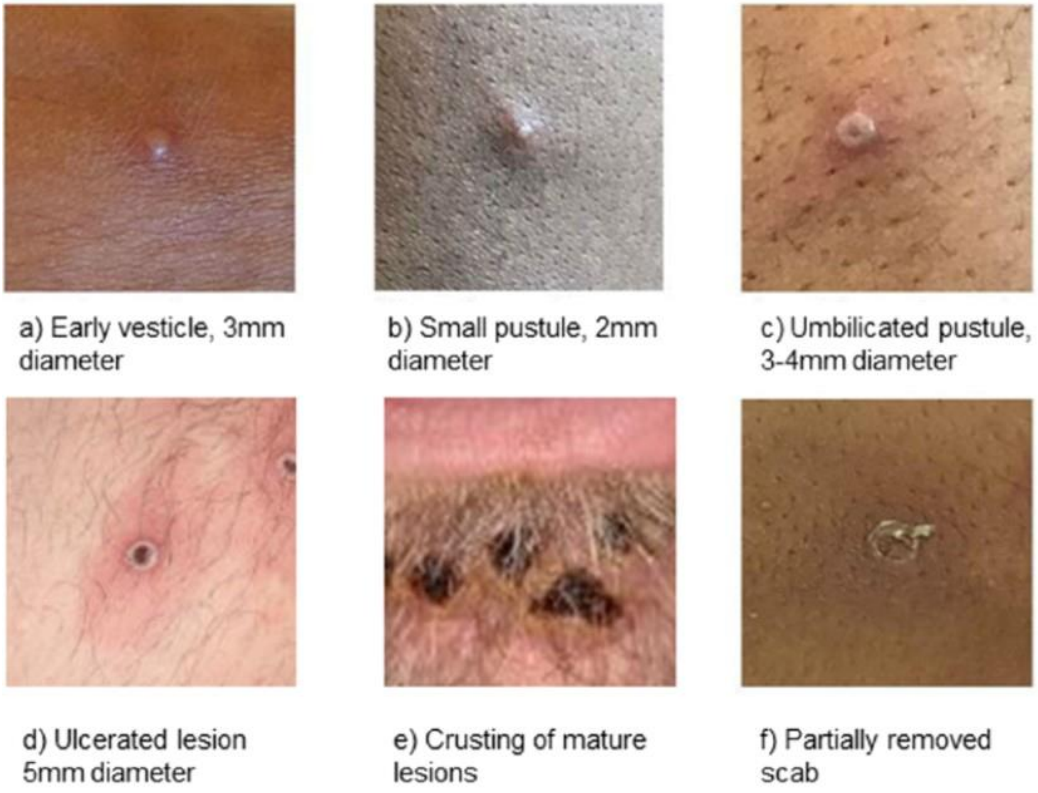
- joint pain

Not all people who have mpox experience all of these symptoms. Within 1 to 5 days after the appearance of fever, a rash develops, often beginning on the face then spreading to other parts of the body including the soles of the feet and palms of the hands. Lesions can also affect the mouth, genitals and anus. The rash changes and goes through different stages before finally forming scabs which eventually fall off.

Some individuals may not have a widespread rash, and in some cases only genital lesions are present. These may be blisters/vesicles, scabs or ulcers.

An individual is contagious until all the scabs have fallen off and there is intact skin underneath. The scabs may also contain infectious virus material.

Images of mpox lesions



a) Early vesicle, 3mm diameter

b) Small pustule, 2mm diameter

c) Umbilicated pustule, 3-4mm diameter

d) Ulcerated lesion 5mm diameter

e) Crusting of mature lesions

f) Partially removed scab

Operational case definition

The following patients should be managed as HCID cases (pending confirmation of clade type where appropriate):

- Confirmed mpox case where clade I has been confirmed
- Confirmed or clinically suspected mpox case but clade not yet known and:
    - there is a travel history to the DRC or specified countries where there may be a risk of clade I exposure, or a link to a suspected case from those countries (listed on page 3), within 21 days of symptom onset and/or there is an epidemiological link to a case of Clade I mpox within 21 days of symptom onset

The countries identified on this list are those where clade I cases have been reported, as well as countries bordering those with ongoing Clade I transmission. They include**: the DRC, Republic of Congo, Central African Republic, Burundi, Rwanda, Uganda, Kenya, Cameroon, Gabon, Angola, South Sudan, Tanzania, and Zambia**. This case definition and country list is available here. Given the rapid spread of

Clade I in the African region, please check the UKHSA mpox pages regularly for any updates to the countries included.

The following patients should be managed using standard mpox precautions (as per National Infection Prevention and Control Manual), and do not require HCID precautions:

- confirmed as Clade II MPXV, or
- confirmed or clinically suspected mpox but clade not known, and all of the following conditions apply:
    - there is no history of travel to the DRC or specified surrounding countries within 21 days of symptom onset
    - there is no link to a suspected case from the DRC or specified surrounding countries within 21 days of symptom onset

Diagnosis, testing and treatment

When assessing a patient for suspected Clade I mpox, clinicians should assess the travel and contact history as above. All cases meeting the operational definition of an HCID should be discussed with the Imported Fever Service (0844 778 8990). Cases where the clade is unknown, but who have a travel or contact history as above, should be discussed with the Imported Fever Service as soon as possible to ensure appropriate testing and escalation**.** Suspected cases should immediately be isolated in a negative-pressure, single room or a single room with dedicated medical equipment. Positive pressure single rooms should not be used. Suspected or confirmed Clade I mpox cases should be managed as a HCID requiring transmission-based precautions and enhanced personal protective equipment (PPE) as outlined in the National Infection Prevention and Control Manual. **Clinicians must notify the local Health Protection Team on suspicion of Clade I mpox and also contact the local Infection Prevention and Control team.**

Most non-HCID MPXV is usually mild and clears up within a few weeks without treatment. Antiviral drugs such as cidofovir and tecovirimat can be used to treat mpox patients with severe disease or those who are at high risk of severe disease.

Vaccination

Currently, vaccinations are being offered to the following groups by sexual health services in the borough:

- Men who are gay, bisexual or have sex with other men (GBMSM), and who have multiple partners, participate in group sex or attend sex-on-premises venues (staff at these venues are also eligible)

Other groups are currently not eligible to receive a vaccination, however this may be updated as the situation develops.

Resources and key contacts

- GOV.UK page on mpox for latest updates
- NHS webpage for mpox

HPT contact details for London

- Phone: 0300 303 0450
- Email: london.region@ukhsa.gov.uk

Local IPC team contact details

- Email: nelondonicb.ipc@nhs.net

Imported Fever Service contact details

- Phone: 0844 778 8990